Virginia Health Practitioners' Monitoring Program
Quarterly Participant Progress Report

Name of Participant: _____ **Client #** _____ **CM:** _____

Date of Report: _____ **For Month:** _____, 20_____

Address/Telephone: _____

Is the demographic information a change from the last report? ☐ Yes ☐ No

Current Medical/Mental Conditions for which I am receiving treatment:

Conditions	New	Ongoing	Medications	New	Ongoing
1. _____	☐	☐	_____	☐	☐
2. _____	☐	☐	_____	☐	☐
3. _____	☐	☐	_____	☐	☐
4. _____	☐	☐	_____	☐	☐
5. _____	☐	☐	_____	☐	☐

Physician Visits:

With primary care provider: ☐ Yes ☐ No Dates of appointments: _____
Provider's name: _____

With other provider: ☐ Yes ☐ No Dates of appointments: _____
Provider's name: _____
Specialty: _____

With psychiatrist: ☐ Yes ☐ No
Number of appointments scheduled: _____ Dates attended: _____
Provider's name: _____

Therapy Attendance:

With individual therapy: ☐ Yes ☐ No
Number of appointments scheduled: _____ Dates attended: _____
Therapist's name: _____

With group therapy: ☐ Yes ☐ No
Number of appointments scheduled: _____ Dates attended: _____
Therapist/Facilitator's name: _____

At treatment facility**:** ☐ Yes ☐ No
Name of Program: _____
Type of facility: ☐ IOP ☐ Outpatient ☐ Residential ☐ Day Treatment ☐ Aftercare

Status of Legal Issues (if any)**:**_____
_____

Current Employer (include address/telephone number)**:** _____
Work site monitor's name (if applicable)**:** _____

Comments/Concerns: _____
_____
_____
_____

(Please fax this form to 804-828-5386 by the 10th of March, June, September and December.)
Thank you for your cooperation!

For Office Use Only
Date Received by HPMP: _____ Case Manager: _____